provide new insights, apply novel techniques and unfold fresh theories at the Eleventh World Congress of Sarcoidosis and other Granulomatous Disorders, to be held in September 1987 in Milan, Italy.

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## Sexual History-Taking

THE INCURABILITY and rapidly increasing fatality rate of the acquired immunodeficiency syndrome (AIDS) have aroused in the medical and health professions a concern about preventive measures that rivals the attention we have for years been giving to the prevention of heart disease and cancer. While researchers focus on possible origins and cures, the immediate challenge for practicing physicians is to determine which patients are at risk of contracting or spreading AIDS. As Lewis and Freeman discuss elsewhere in this issue, we already know that sexual life-style is one of the leading AIDS risk factors, and, therefore, it is necessary to ask patients about their life-styles as part of a comprehensive health care evaluation. But talking about sex, or sexual life-styles, presents a different sort of challenge than talking about diet, smoking or exercise, risk factors for other common diseases.

Lewis and Freeman point out that physicians, because of personal discomfort, have difficulty discussing sex with patients who may have same-sex partners. Ample literature indicates there is a wide variety of sex-related topics that are difficult for physicians to discuss. Talking about sex with elderly patients, or severely disabled patients, or discussing extramarital or premarital sex, may arouse discomfort and avoidance. Numerous studies have been done to determine the best teaching methods to improve comfort and knowledge levels through medical school and continuing education courses on human sexuality.[1,2]

Unfortunately, similar studies have not been done on how to best put to clinical use sexuality comfort and knowledge. Many questions remain in regard to how to best incorporate a sexual history into routine medical history-taking. What is the difference between taking a sexual history in a psychiatric setting and in a general medicine practice, and where are the scientific studies of the effectiveness of one type of sexual history-taking versus another in eliciting medically useful information or information of therapeutic value in a nonpsychiatric setting?

Various approaches to sexual history-taking by physicians have been recommended in textbooks and articles.[3-5] Two of the more obvious areas of conflicting recommendations have to do with how to initiate the discussion of sexual function, and the minimum of questions that should be asked of patients during history-taking in nonemergency situations. Green suggests initiating sex-related questions with a variation of:

> One area of health which has been relatively neglected by physicians in the past is sexual health. It has become increasingly apparent that if we are to fulfill all our responsibilities to patients this important part of our lives must also receive attention. Therefore, I am going to ask you a number of questions about sexuality. . .[6]

Using such qualifiers as openers is refuted by others who suggest eliminating opening rationales and asking directly about sexual function, getting the sexual physiology particulars when other physiologic questions are being asked during a routine review of systems.[7,8] A few direct questions during a review of systems might be the more efficient and effective way of introducing the topic of sex and determining if there are any risk factors or problem areas that warrant further exploration. Reich states that patients appreciate direct questions (not "how is your sex life?") and that screening questions should be routine. "Otherwise, the physician may overlook problems, may return to the subject as an afterthought, or may experience tension or show embarrassment when trying to think of a screening question during the history."[8]

When asking questions about the genitourinary system, it is logical to ask women about vaginal pain and men about erectile function. Such direct functional questions pave the way to questions about sexual activity: frequency, partners, satisfaction. A direct manner of asking about sexual activity invites a direct response, such as "Do you have more than one sexual partner? Is (Are) your partner(s) male or female (or both)?" We must not assume people are monogamous or heterosexual just because they are married. We must not assume they are celibate if they are single, elderly, disabled or in some way could be considered unattractive.

When a physician shows a willingness to talk about physiologic specifics and alternative life-styles, the patient is prepared to respond frankly to follow-up questions such as "How has your present illness (disability) affected your sexual functioning or relationships?" and "Do you have any concerns about your sexual functioning?" This method of going from specific questions to general ones is contrary to the usual sequence in history-taking, but may be a good way to invite a frank response to the general questions. When the general questions and questions about sexual satisfaction and behavior are asked first, the patient is not sure how specifically or openly to respond.

Munjack and Oziel clearly distinguish between a screening history and a problem-oriented history.[9] Others recommend a single detailed history-taking that includes questions about sex education, masturbation practices, sexual fantasies and a wide variety of questions that may not be practical for inserting in the routine history-taking format of most general medical evaluations. Singling out the sexual area of a patient's history for a 20-minute review may turn away patients who do not understand the relevance of such detail unless they have expressed a sexual concern. Obviously, once a concern is expressed, further exploration is necessary for proper diagnosis, treatment or referral.

Both physician and patient must accept the relevance of the sex-related questions if the physician-patient relationship is to be maintained or enhanced by such frank discussion and

if medically essential information is going to be elicited. Using a brief screening history, followed by a problem-oriented history when indicated, physicians in one study found that asking patients about their sexual functioning was of medical value in 50% of cases. In this study, 98% of the patients who had been asked about sexual function reported that this questioning was appropriate.[10] The study predated the AIDS epidemic.

Medical value and appropriateness were reported when the issues raised by sexual history-taking had more to do with the quality of life than the threat of loss of life. While AIDS may be an important impetus to begin including sexual histories in medical history-taking, it would be unfortunate if the sexual history is only valued for its ability to disclose risk for a life-threatening disease. When sexual problems go unrecognized, they may become the basis for nonsexual presenting complaints such as insomnia, headaches, backaches, depression or vague somatic complaints. Literature on sexuality and cancer, renal disease, spinal cord injury and countless other diseases or disabilities emphasizes that attention to sexual concerns and dysfunctions can have a positive impact on physical and emotional well-being.

Through sexual history-taking physicians can determine if sexual problems are the result of the use of drugs or alcohol, the presence of vascular or neurologic disease or other diseases or disabilities, the treatment of which might alleviate the sexual problems. Each year with persistent exploration of problems in sexual function, research increases our understanding of the interconnection between sexual function and other aspects of the physiologic system. Whereas ten years ago most sexual problems were considered psychological problems, today we have discovered the adverse impact of vascular disease on erectile function, radiation treatment on libido, drugs on libido and erectile function and many other areas in which sexual problems prove to be medical in origin. Improved routine sexual history-taking is likely to suggest more answers to the questions that remain for sexual problems that do not improve with psychiatric treatment.

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## Are We a Violent Nation?

THERE HAS BEEN violence in this world for a long time, probably since long before recorded history. We like to think of ourselves as a peaceful nation. Certainly we yearn for peace, even while we are upgrading our national armaments as a deterrent against needing to use them. Even so, we found ourselves in four major armed conflicts in the name of peace during the present century. There surely was violence in these conflicts, but this violence was deemed necessary, and, in the context of the times, even unavoidable. But does this mean that we are really not a violent nation? By one means or another we seem to have acquired most of what we need, and as a nation we have no reason for aggression or to use violence to achieve expansionist goals. In fact quite the contrary—we would like nothing more than to live in a world genuinely at peace. Some other nations are less fortunate, and some are aggressive and may even resort to violence in an effort to achieve their perceived goals. So it seems certain that there will continue to be violence in the world in which we live.

But when we look at ourselves internally there is considerable evidence that many Americans really must enjoy violence for whatever reason. One needs only to watch the newscasts on television, read the newspapers, scan the offerings at the movies (particularly the violent and horror movies so enjoyed by young people), to sense that the public at large must have more than a casual interest in violence, not to mention crime. Even the "Star Spangled Banner," the national anthem, has its "bombs bursting in air," while the more peaceful "America the Beautiful" has never achieved status as our national anthem.

One can only wonder if there is a difference between what we say we are—a peace-loving people—and the aggressive, competitive people we seem to be, also a people that somehow enjoys or seems to get some satisfaction—vicarious or otherwise—out of violence. One can only guess at what effect all this imagery of violence has on our people, especially the young people. When one sees small boys gleefully shooting at passing automobiles (or at each other) with toy hand guns, one can only wonder where they got the idea. And their parents may very likely have given them the toy guns and, if so, where did they themselves get the idea? It is hard to believe that such things do not reflect a tacit acceptance of violence as a more or less integral part of the life of this nation and a tacit acceptance of a special interest in violence by the media.

Americans must remain an aggressive and competitive people if they are to hold their own in this modern world. They must learn how to be aggressive and competitive in an aggressive and competitive world, and many of them must learn this through the imagery of the news media. But must we accept or condone the exploitation of violence that we see all about us, recognizing that this very exploitation can lead to further violence that can then be exploited?

Physicians are familiar with the aftermath of violence. They try to repair the injuries, whether physical or emotional or both. They know the cost in dollars and human misery. Perhaps it is time for the medical profession to be more active in the prevention of violence, if not aggressiveness. True, the profession has already spoken out against violence, perhaps even with some effect. But the imagery not only persists, it is thriving. Physicians are respected when they speak with authority on matters of illness and injury. Perhaps it is time to document the correlation between violent imagery and violent action, and then to speak and act even more forthrightly in the interests of patients, the public in this matter, as we proceed in our quest for a healthier nation.

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